CATAWBA REGIONAL PARTNERSHIP
LEADERSHIP TEAM

STRATEGIC PLAN

1. REGIONAL PARTNERSHIP MISSION, VALUES STATEMENT AND STRATEGIC DIRECTION

A. Mission: The Catawba Regional Partnership Leadership Team will create a collaboration of public and private providers that engages, treats and supports people with mental disabilities in a consistent and readily accessible manner through appropriate levels of care and intervention to maximize recovery and quality of life.

B. Values: The Catawba Regional Partnership members strive to make services to those individuals with mental illness available at the time and place most conducive to the recovery of the individual. The services should be appropriate in content and structure to facilitate the individual making a choice of services which they assess to be most beneficial to their situation.

C. Strategic Direction: In its submission dated August, 2003, the Partnership in the Catawba Region focused on programmatic improvements that would build capacity to provide a limited number of services to a limited number of clients. These clients were often those who were not immediately able to access treatment or other support services in the community. The emphasis was on creating programs to treat individuals with mental illness in the least restrictive setting feasible. To this end, the initial focus was on developing the following programs:

- Transitional housing options as a step-up or a step-down alternative to hospitalization Status: deferred due to no funding being available
- Hospital-based psychosocial rehabilitation for some individuals unable to access this through the BRBH Mountain House program. Status: to be implemented by 12/31/04.
- Increased access to psychiatry services, possibly with the option to be transitioned from inpatient to outpatient treatment with a single practitioner. Status: deferred due to lack of Catawba Hospital psychiatric capacity.
- Increased access to pharmacy services in a more efficient and economical manner by creating a BRBH-based pharmacy in conjunction with the Catawba Hospital pharmacy. This has more recently been redesigned as a partnership between BRBH and the local Health Department. Status: completed and submitted a design for the regional community-based pharmacy for regional clients eligible for state aftercare pharmacy services

to DMHMRSAS and DH. The plan awaits final contract negotiation with DMHMRSAS for implementation.

- Improved practices and services to facilitate increased communication among the regional treatment providers which would promote more effective and efficient provision of services to the region's individuals with mental illness. Along with this, alternatives to inpatient treatment would be developed. Status: completed and prepared for distribution a "Roadmap to the Community" for new and current consumers and families

During the past year, the Catawba Region has been faced with an increasing inpatient bed demands resulting in serious capacity limitations in both public and private area hospitals. Consequently, our Regional Partnership has shifted its focus in the past few months to determine the causes of and potential remedies for this problem. The impact of this inpatient issue is felt throughout our system of care and therefore, must be identified as our priority concern. The Partnership has identified four initial aspects of the regional problem as follows:

- Impediments to serving individuals with mental illness who are in crisis, with the goal of improving crisis services available
- Insufficient availability of inpatient psychiatric acute care services
- Specific populations that placed stress on our acute care capacity
- Communication barriers between inpatient and outpatient service providers in both the public and private sector.

2. OVERVIEW OF REGIONAL PARTNERSHIP STRATEGIC PLAN

A. Accomplishments: During the past year, the Catawba Partnership has

- completed and submitted a design for the regional community-based pharmacy for regional clients eligible for state aftercare pharmacy services. The plan awaits final contract negotiation with DMHMRSAS for implementation.
- completed and submitted a design for community-based clients participation in the Treatment Mall at Catawba Hospital
- completed and prepared for distribution a "Roadmap to the Community" for new and current consumers and families
- completed and submitted a design for transitional housing that has remained unfunded
- removed the originally identified need for PACT services in the AHCSB region demographics and lack of resources In place of the PACT, a hybrid service was substituted. The new service requires availability of a physician for after hours telephone consultation, as well as crisis stabilization

and intensive community supports. AHCSB is now licensed to provide this service to clients in the service area.

B. Description of Process:
    1. the original process engaged all stakeholders including advocates, families and consumers, private and public providers. The Leadership Committee then formed a workgroup to address each priority area. Individuals from each of the participating agencies as well as advocates were appointed to the workgroups to review the existing services and to develop improved processes in their specific area.
    2. during the past year, the Leadership Team has spent a significant amount of time evaluating the larger systemic issues outlined in the original proposal to DMHMRSAS in early 2003.
        - "At present, the availability of acute inpatient psychiatric beds is non-existent or decreasing in this region. Over the years DMHMRSAS proposals and reports, regarding bed-purchase strategies, have cited Carilion Roanoke Memorial Hospital, Carilion St. Albans Hospital and Lewis-Gale Hospital as sources of these beds. St. Albans is closing their facility and will be transferring the property to Radford University. Roanoke Memorial Hospital has reduced their staffing and the functional capacity of their psychiatric units in the recent past, and the future status of inpatient behavioral health services is unclear at this time. Lewis-Gale Hospital has historically operated a relative small unit and has not had the capacity or the expertise to treat the demanding SPMI population served by Catawba Hospital. Additionally, Allegheny Regional Hospital has closed an inpatient behavioral health program during the past decade, making services even less available to the Allegheny-Highlands CSB area. The current CEO and the three previous CEOs of that hospital have been firm in their view that this is a permanent decision. Catawba Hospital serves the patients. It is the safety net for the system."
    3. Leadership Team spent a day and a half in retreat determining the next actions to be taken toward developing its comprehensive system of care

3. SUMMARY OF REGIONAL PARTNERSHIP'S STRATEGIC ASSESSMENT

A. Constituent and consumer expectations – Consumers, advocates and providers agree that a seamless system of care that is built on collaboration is the common goal. Elimination of systemic barriers

created by disparate provider systems must occur to insure quality psychiatric care in the region.

B. SWOT analysis: The Leadership Team identified the strengths and weaknesses of the systems operating to service people with mental disabilities in the region.
    - Strengths: experienced, savvy leadership, excellent community programs evidence-based in origin, critical linkages, education/training opportunities for staff, and, two willing emergency departments, demonstration of POS in region through KOKAH project, detoxification programs, forensic expertise and over 400 psychiatric beds including geriatric and NGRI beds
    - .weaknesses or barriers: regulatory and legislative disincentives, trends toward DAP/Waiver funding initiatives, rigid organizational boundaries, inability to access client information or services esp. after hours and weekends, different systems have different care models, no services for special populations, diminishing resources with increasing demand for services
    - external opportunities: LIPOS funds
    - external threats/challenges: potential loss of inpatient capacity in private sector which will place an unmanageable burden on the entire state inpatient system; increasing demands for care for uninsured people vis a vis the decreasing infrastructure and funding supports

C. Emerging external political, economic, social and technological trends:
    - political: dwindling local tax base, public/private relationship at risk due to resource demands and expectations of the public sector continuum of care, financial viability of continued provision of inpatient psychiatric care in the absence of reimbursement
    - economic: potential loss of private provider bed capacity due to decreasing revenues, trends to DAP/waiver-type endowments at the expense of infrastructure, shrinking infrastructure inhibits CSB ability to address client needs pre- and post- hospital admission
    - social: increasing numbers of medically indigent ineligible for Medicaid or other third party payers; increasing numbers and advocacy for people with acquired brain injuries
    - technological: high impact of required documentation delineating outcomes in the absence of implementation of digital signatures, increased and redundant paperwork demands for waiver and state plan options Medicaid programs

D. Brief description of opportunities for achieving operational efficiencies and cost savings:
    - Expanded crisis diversion opportunities would reduce the annual cost of inpatient treatment

- Reduce the number of unreimbursed bed days in private facilities through LIPOS and improved crisis diversion
- Utilize certified state hospital beds to provide care
- Develop opportunities and strategies for advocates and individuals with Acquired Brain Injury so that inpatient care is managed more appropriately and non-hospital based services are identified
- Increased and improved information flow to reduce redundancy in paperwork, lower barriers and improve the continuum of care
- Implementation of community-based pharmacy and community-based psychopharmacology team to assist with reduction of medication management conflicts.

4. CRITICAL ISSUES FACING THE REGION

A. crisis/acute care at capacity
B. non-existent treatment for special populations, esp. Acquired Brain Injury
C. limited/poor access to information and treatment esp. after hours/weekends
D. different systems have different treatment modalities and rigid boundaries

5. STRATEGIC GOALS, OBJECTIVES, AND STRATEGIES

A. Region will provide a comprehensive system of appropriate crisis diversion and treatment, both inpatient and outpatient, for adults with mental illness and a co-occurring disorder such as mental retardation or substance abuse, if present.

A.1 crisis stabilization capacity

A.2 develop increased response to crisis clients that can avoid admission to hospital with intensive supports and case management

A.3. Purchase of inpatient beds for patients post commitment awaiting transfer to Catawba Hospital

A.4. Increase communication and cooperation between CSB Crisis Services programs, RESPOND (L-G) and CONNECT (Carilion)

B. Region will explore and develop alternative treatments for adults with acquired brain injury in cooperation with the Brain Injury Association of SW Virginia

B.1 liaison with BIASWV to determine appropriate methodologies and resources for people with Acquired Brain Injury

B.2. receive education and guidance from BIASWV and health care systems to determine most appropriate care for patients with brain injury requiring structure and control

C. Region will insure access to critical information following appropriate AHIMA/HIPAA regulations within 24 hours of request.

D. Region will develop an appropriately manned task force to address treatment protocols and critical pathways for common treatment modalities across the region.
   D.1 engage University of Virginia Medical Education/Residency
   D.2 identify most appropriate individuals from area institutions and agencies to define common areas of treatment concerns
   D.3 establish clear objectives and timelines for completion of the task with disincentives for noncompliance

REGIONAL PARTNERSHIP RECOMMENDATIONS FOR STATE-LEVEL ACTION

Several recommendations for state level action were submitted in the document of August 2003. Most of those recommendations have been resolved. The remaining task is the finalization of the Pharmacy plan by completion of Memoranda of Understanding between DMHMRSAS and BRBH. At that time, BRBH and the Health Dept. are ready to proceed with the community-based pharmacy.

ATTACHMENTS

1. Description of pharmacy project with Roanoke City Health Dept.
2. Draft Memoranda of Understanding regarding the community-based pharmacy
3. Position description of the Project Manager
4. Document describing regional use of DAP funds allocated in FY-05
5. Document describing regional use of LIPOS (bed purchase) funds in FY-05

FINAL REPORT AND RECOMMENDATIONS OF THE REGION 7 CFS PARTNERSHIP COMMITTEE

August 3, 2004

Overview

Planning for this project began with state and local advocates on July 5, 2003. The Steering Committee was formed at the request of the Region 1 Leadership Team has met on a regular basis throughout the past year.

Committee Activities

Steering committee membership included representatives of the following private and public partnership organizations:

- Voices for Virginia's Children: Margaret Crowe, Senior Policy Manager
- Roanoke Valley Alliance for Children: Natalie Webster, Chair
- Mental Health Association of the Roanoke Valley, Diane Kelly, ED
- NAMI of the Roanoke Valley, June Poe
- RAYSAC/ Roanoke County Schools: JoAnn Burkholder, SAP Director
- Roanoke County CPMT/ Parent Representative: Rita Gliniecki, Chair
- Lewis Gale Center for Behavioral Health: Margie Twigg, Supervisor
- Roanoke City Schools: Cynthia McLearn, Office of the Director of Guidance
- Alleghany Highlands CSB: Doreen Davis
- BRBH: Gina Wilburn, CFS Director

This committee at the onset developed the following guiding principals:

Mission Statement: To develop, advocate for and implement a single comprehensive system of care for child and family services

Goals:

1. To define the ideal CFS system of care;

2. To identify strengths and challenges facing the CFS system of care in the community;

3. To review existing research and community models to support development in the local and state CFS system of care;

4. To make recommendations to enhance the community's current system of care; and

5. To identify the role of the Community Services Board within the community's CFS system of care

Objectives:

1.1 The Steering Committee , with the inclusion of broad-based Stakeholder feedback, will develop consensus on a definition of local ideals/ standards by 9-03;

2.1 Collect information through open, public stakeholder meetings utilizing the SWOT format by 11-03;

3.1 Identify existing research for needs identified via the stakeholder SWOT process by 1-04;

3.2 Cross-reference evidence-based practice data with Secretary Wood's on-going CSA workgroup by 2-04;

3.3 May elect to visit any other model of care identified as applicable to locally identified service needs

4.1 and 5.1: Compile data from all objectives and provide/ present formal recommendations to the Leadership Team by 8-04;

4.2 Provide local representation to state Special Population CFS Work group on an on-going basis throughout the year;

5.2 Analyze all Goals and Objectives outcomes and determine priority service areas for CSB to pursue by 5-04;

5.3 Advocate for specific state funding stream for CFS, on an on-going basis; and

5.4 Explore further diversity of funding streams and/or private funding and advocate for insurance parity, on an on-going basis

Outcome Information

- **Development of Guiding Child and Adolescent System of Care principles for local service system recommendations:**

Margaret Crowe and Gina Wilburn provided representation to the State CFS Special Populations Workgroup. This assisted in facilitation of a more informed local process in relation to state-wide activities. Part of the work of the state committee was to research and educate its members in best practice systems of care. The local committee made a decision to adopt this work and the values and principles noted in the large body of literature on child and family systems of

care, DMHMRSAS policy and state workgroup reports, such as 329-G, instead of engaging in a duplicative process. The recommendations of this committee reflect the following core values and principles in efforts to further build a more complete local Child and Family Services system of care. These values and principles are as follows:

- Child-centered and family focused
- Community-based
- Culturally competent and responsive to special needs
- Least restrictive environment that is clinically appropriate
- Comprehensive array of services inclusive of home and community-based alternatives
- Broad, flexible array of services and supports
- Families/ youth are full participants in all aspects of planning and delivery of services, management and policy developement
- Integrated services
- Individualized services guided by individualized service plan
- Individualized service “wrapped around” child/ family
- One accountable Care manager
- Care coordination and collaboration across agencies
- Single plan of care
- Interagency/ family services planning teams and monitoring teams
- Early identification and intervention
- Smooth transitions
- Rights protected and effective advocacy effort promoted
- Receive services without regard to race, religion, national origin, gender, physical disability, or other characteristics
- Integration of clinical treatment services and natural supports, linkage to community resources
- Integration of evidence-based and effective practices
- Organized pathway to services and supports
- Shared outcome across agencies
- Adequate and flexible funding
- Blended, braided of coordinated financing
- Seamless access, equity and efficacy of services

- **Identification of Local Strengths and Weaknesses in current Child and Adolescent System of Care:**

Two public hearings occurred on October 28, 2003, and November 13, 2003 from 7:00 to 8:30 PM. The first hearing was at Lewis Gale Education Center in Salem, VA and the second in the Botetourt Board of Supervisors Meeting Room. These hearings included a welcome, brief overview of the restructuring/reinvestment planning process, a SWOT format for facilitating

feedback and a wrap-up and time for participants to collect informational hand-outs. Margaret Crowe was the lead moderator for the first hearing and Diane Kelly was the lead moderator for the second hearing. A summary of local strengths and weakness identified during these processes are as follows:

Strengths:

Roanoke

- Good psychiatric residential program within an hour's drive
- Day treatment programs in the schools
- MHA/ NAMI/ CSB support and education classes for parents

Botetourt

- In-Home Services, including development of parenting skills
- Day Treatment
- One-to-one aides

Weaknesses:

Roanoke

- Appropriate group homes lacking in the Roanoke Valley
- Local private hospitals not interested in developing residential services
- Children involved in CSU or DSS are linked into services and tend to have more comprehensive treatment than children who are demonstrating problems within the school setting
- Lack coordinated information about what services are available for SED/MR/SA youth
- No before and after school or summer programming for this population
- Acute psychiatric hospitalization is too short and full assessments are not done
- No parity for private insurances for services such as Case Management, Therapeutic Day Treatment, Intensive In-Home Services
- There are more services for low-income families than for middle-income families and this sometimes results in parents petitioning for relief of custody to acquire financial funding for needed services
- Parental involvement in children's services is sometimes low or nonexistent: Parents need to feel more empowered, better educated about services, build trusting relationships with service provider(s)
- Lack of adequate child psychiatry services-long waiting list, or doctors who are not taking new patients. Some doctors will not accept Medicaid.

Botetourt

- Lack of After-School care for special needs kids
- Transportation
- Lack of Medicaid reimbursement

Opportunities:

Roanoke

- Young child (0-4) treatment services for at-risk SED or SED population including child psychiatry services
- More education for pediatricians, schools, community, parents
- Training in schools for non-education staff related to needs of these special populations
- More advocates available to understand IEP process and assist families
- Parent Resource Centers create more accessibility to parents
- Case Manager be allowed to take an active role in the IEP process

Botetourt

- Better medical diagnostic facilities
- Increase staffing levels/capacity in existing services
- Respite care provided by trained professionals
- Parent support groups
- Service needs for non-special education children given same level priority
- Development of a Diagnostic/Assessment Center with varying intensity or different levels of assessment
- Adolescent Substance Abuse services
- Special attention given to summer programs for elementary and middle school level special needs children
- More day treatment options for children in elementary, middle and high schools
- Sibling education/support groups
- Appropriate, affordable inpatient treatment for SED and SA children

Threats:

Roanoke

- Roanoke County Career Center (School) may eliminate program-where would these children be served since there is a lack of choices/programming for children with various learning styles
- Structure of day for some special education programming is no similar to regular education schedule

Botetourt

- Gaps in services created by pre-authorization procedures
- Treatment compliance
- Transportation
- Lack of Medicaid and other insurance reimbursement for services
- Lack of public awareness; Stigma
- Poor knowledge base about effectiveness of treatment

- Ineffective; inefficient referral network
- Lack of child behavioral healthcare professionals
  0-5 population is very high risk
- Long waiting periods for services

- **Identification of gaps in Local Child and Adolescent System of Care**

A survey was made available to all CORE agencies and private providers within the catchment area. The instrument developed and used by the Richmond Behavioral Health Authority was amended to include only the child and adolescent population. The instrument used is attached. Results were collated by VPI&SU.

The results of this survey follow:

Populations meeting the 50-75% threshold
Barriers to school Success SED(18:29),
Juv. Justice SED (16:29)
Sex Offender SED (15:29), MR (15), SA (15)

Populations meeting the 25%- 50% threshold:
DSS population SED(12:29)
Barriers to school Success SA(12:29); other at-risk (12)
Infant-Toddler SED (9:29)
Juv. Justice SED MRDD(9:29), SA(13) OAR(9)
Sex Offender OAR (10:29)
Significant Medical SED (10:15), MR (9)
Homeless SA (10)

Service Needs (25-50%, *** 50-75 %)**
Prevention/ Early ID (4:29)
Early Intervention (5)
Outpatient Support (4)
Mental Health Supports (4)
Parent Support/Education (11)**
Mentoring (6)
Respite (2)
Behavioral Aide (4)
Transition across all disabilities (20)***
Case management across all disabilities (12)**
Outpatient Diagnosis and Assessment (5)
Intensive Outpatient Program SA (10)**
Ind/Family Therapy across all disabilities (20)***
Psychiatric Services (12)**
Outpatient Group Therapy (3)

Therapeutic Day Treatment, School (4)
Therapeutic Day Treatment, After school (7)**
Intensive In-Home (4)
Crisis Intervention (5)
Crisis short-term counseling (6)
Residential 90 day Assessment (10)**
Acute Hospitalization (6)

In addition to the Service Needs survey results, the committee used both feedback via the Stakeholders' meeting and information contributed by CORE agencies or local workgroups including the schools' Youth Behavior Risk Survey results, CSA Data and Roanoke Interagency Council 's best practice Unmet Needs Report and Long Range Action Plan, CSA Southwest Regional Steering Committee and the Roanoke Valley Advocacy Coalition's identified gaps and priorities for children's services. This additional information was used to further inform the recommendations.

Recommendations

1. BRBH should develop additional capacity for traditional front door, outpatient services inclusive of stand alone Assessment and Intake and as well additional Outpatient therapy availability.

2. BRBH should further examine the ability to increase psychiatric capacity within the current system of services.

3. BRBH should provide support and leadership, in partnership with other core agencies to develop interagency guidelines for transition of youth into adult services.

4. BRBH should partner with other child-serving agencies to develop a "road map" for child and family services across the broader service system of core agencies and private providers.

5. BRBH, as a agency staffing the CSA Regional Steering Committee, will continue to provide support for the successful attainment of the committee's primary goal: to develop a short-term evaluation and residential facility within the region.

Barriers to the process: The Steering Committee identified several issues that include:

- Lack of clear directives for how the children's special populations efforts should be organized;

- Lack of information regarding how children's special populations work will fit into the larger reinvestment/restructuring outcome;

- Lack of consistency in the various regions in approaching the children's partnership process;

- Labor intensity of project and time constraints for members; and

- Lack of clarity about how dollars can be spent for activities planned.

CATAWBA REGIONAL RESTRUCTURING PHARMACY PROJECT

INTRODUCTION:

A community-based pharmacy for aftercare medications will provide BRBH with funds and control to manage a formulary that will meet the needs of its clients. It will reduce costs and be a more efficient and normalizing method of providing medications to our clients. Full participation of the Alleghany-Highlands CSB is available at such time as that CSB would find it a valuable alternative.

The Health Dept. Pharmacy and BRBH will form a partnership that will allow BRBH to maximize its purchasing power, to reassign medication delivery tasks away from nursing personnel, and potentially include clients that do not currently have access to the benefits of the state-operated aftercare pharmacy.

LEGAL STATUS:

A contract and memorandum of agreement will be executed by all parties, the Alleghany Health District Pharmacy and Blue Ridge Behavioral Healthcare. Medicaid provider number(s) will be obtained by the Health Dept. for billing purposes.

FUNDING:

The Dept. of Mental Health, Mental Retardation and Substance Abuse Services will transfer funds in the amount congruent with the other CSBs using the Aftercare Pharmacy. The frequency/schedule of disbursements will be determined at a later date. The funding will always be allocated based on the same formula used for all CSB allocations to the Hiram Davis Aftercare Pharmacy. Special funding received through legislative or other action will also be shared equally with BRBH. At no time will the funding to this project fall below the standard allocation for all other CSBs using the state aftercare pharmacy.

The Health Dept. will not charge any fees to either CSB for filling prescriptions. Any Medicaid reimbursement money will be credited to the CSB account.

PERSONNEL:

BRBH will hire a full time pharmacist who will be stationed at the Health Dept. pharmacy. The pharmacist will work as part of the Health Dept. Pharmacy team. The salary and fringe benefits will be prorated between the two CSBs based on percentage of money from DMHMRSAS. The pharmacist will work the same hours and schedule as the Health Dept. pharmacy team. The pharmacist will provide back-up and support to the team in general, not limiting the tasks to this project alone.

BRBH will also pay one-half the salary of 1.0 FTE CPT (certified pharmacy technician) employed by the Health Dept.

Nursing personnel at Psychiatric Services will be assigned duties more in line with appropriate nursing functions. Each LPN will work cooperatively with a fixed number of psychiatrists/residents at Psychiatric Services. Their tasks will be to provide support to the doctor and patient, to evaluate general health issues with the patient and to insure that the patient has access to medicine through various channels. The current technician assigned to the medication room at BRBH will be devoted to managing all pharmaceutical indigent programs paperwork/applications.

ELIGIBILITY FOR SERVICES:

Eligibility of services is limited to clients of BRBH who

- have been treated in a Virginia state hospital and have financial need (income less than twice the poverty level)
- no Virginia state hospitalization but has been prescribed an atypical antipsychotic medication and meets the above financial need description. Eligibility is limited to atypical antipsychotic medications
- discharged from a state hospital in another state within the past thirty days, continued to receive outpatient care including medications in that time period, and meets the financial need criteria

While a proven financial savings resulting in a positive balance statement will allow the community-based pharmacy to add other groups of individuals in need, the partnership will actively seek additional ways and means to support the clients listed below Examples of those groups may include:

- Hospital diversion clients, such as, people in temporary detention at Shenandoah Recovery Center, clients admitted to Carilion Rehabilitation Center or Lewis-Gale Pavilion who meet financial need criteria and are clients of BRBH
- Children in the KOKAH project ineligible for other child health entitlements
- All open clients of BRBH who meet financial need criteria but have no insurance

FORMULARY:

The formulary will be established to reflect the Catawba Hospital psychiatric medications formulary. The BRBH Medical Director and the CSS Clinical Services Director will sit on the Catawba Pharmacy & Therapeutics Committee to insure that formulary needs are determined jointly with Catawba psychiatric personnel. The purpose would be to insure the appropriate medicine that is most accessible to the patient due to cost and availability is mutually identified and agreed upon for the formulary.

The Health Dept. will be responsible for keeping the formulary stocked based on demonstrated client need. Indigent medications ordered by BRBH staff will be transferred to the Health Dept. pharmacy for distribution to the appropriate client. Indigent medications are delivered by the pharmaceutical companies to the address of the prescribing physician. Once received, the prescription will be carefully identified by client name and will be sent to the Health Dept. pharmacy by way of the daily courier services (provided by Health Dept.)

Non-psychiatric medications will not be available to BRBH clients through this funded program. However, BRBH clients with 3rd party coverage who use the Health Dept. pharmacy for their aftercare psychiatric medications can also fill their non-psychiatric prescriptions at the Health Dept. BRBH clients with Medicaid or other third-party prescription benefits are encouraged to have their other prescriptions filled by the Health Dept. pharmacy to insure quality pharmaceutical care and monitoring of client medication regimens.

PROCEDURES:

When the CSB client is seen by the psychiatrist and a prescription is written, it will no longer be on the Aftercare Prescription card. A regular prescription form will be used. The prescription will be given to the nurse affiliated with the specific physician who will briefly meet with the client before he/she leaves the building. Based on the client's eligibility (see ELIGIBILITY above), the prescription will be marked with either an "A" for "aftercare" or an "I" for "indigent" if either status applies. Clients with Medicaid or other financial resources will not have the prescriptions marked in any way. Clients with financial resources will be encouraged but not required to use the Health Dept. pharmacy.

The clients with "A" or "I" prescriptions will present the prescription to the Health Dept. pharmacy for processing. The Health Dept. pharmacist will pour the medications at that time. There will be no pre-poured medications dispensed from the Health Dept. pharmacy site.

The "A" clients will receive their medications from the stock maintained by the Health Dept. pharmacist. The "I" clients will receive their medications from the specifically identified bottle delivered from the pharmaceutical company to Psychiatric Services and transferred to the Health Dept.

Pre-poured medications will be delivered to either BRBH Psychiatric Services(as needed) office for distribution by the CSB nursing staff. Injectible medications will also be delivered to the CSB nursing staff for administration. CSBs will notify the Health Dept. pharmacy by FAX as allowed by law of any prescriptions needed to be delivered to the individual CSB medication locations.

Each prescription filled will be logged into a pharmacy computer program that will track all medications, dosages, patients, and cost. BRBH will have a separate

account at the Health Dept. Monthly invoices with a complete listing of all medications distributed from the Health Dept. regardless of whether they were delivered to a CSB office or not will be mailed to BRBH for review and approval. All billing will be handled through the individual CSB's accounting system.

MANAGEMENT AND OVERSIGHT:

BRBH will identify one individual to serve as the CSB's responsible person to manage and monitor this project. This person will be identified as the Pharmacy Project Leader at the CSB. Those individuals will report any systemic problems to the Pharmacy Workgroup appointed by the Catawba Leadership Team for review and remediation. Daily problems will be handled directly with the pharmacy manager at the Health Dept.

Financial status reports will be prepared monthly for review by the Pharmacy Project leaders and the Health Dept. pharmacy staff. A final approved financial statement will be delivered to the Catawba Leadership Team monthly for the first year. Assuming a successful year, the reports may be sent quarterly thereafter.

Monthly meetings between relevant BRBH and Alleghany Health District pharmacy staff will be utilized to refine the processes and resolve any issues or concerns. The Catawba Hospital pharmacy staff will be available on consultation as needed.

Annual reports including outcome measures and financial management will be presented to DMHMRSAS along with the 4th Quarter Report on the Performance Contract.

MEASUREMENT OF SUCCESS:

The success of this project will be evaluated based on the following:

- Hospital recidivism based on medication issues
- Number of people served
- Number of units/dollar spent
- Financial management

The Catawba Partnership Project Manager will develop a database program and will determine reporting mechanisms to track this data.

MEMORANDUM OF AGREEMENT
between
Blue Ridge Behavioral Healthcare
and
Roanoke City and Alleghany Health Districts

Community Based Pharmacy Program

This Memorandum of Agreement between Blue Ridge Behavioral Healthcare (BRBH) and Roanoke City and Alleghany Health Districts (RCAHD) in consideration of the mutual covenants and stipulations set forth herein and in order to establish their responsibilities with respect to the purpose of this agreement, agree to the following:

I. PURPOSE

The purpose of this memorandum of agreement is to establish a partnership between Blue Ridge Behavioral Healthcare and Roanoke City and Alleghany Health Districts and define the roles and responsibilities of each in the provision of community based pharmacy services to the clients of Blue Ridge Behavioral Healthcare.

II. Obligations of the Partners

A. The Health Districts will:

1. Operate a walk-in pharmacy, in accordance with the regulations of the Commonwealth of Virginia, State Board of Pharmacy, at 515 Eighth Street SW, Roanoke, VA 24016 to provide services for clients of BRBH.
2. Fill and refill prescriptions at acquisition cost for clients of Blue Ridge Behavioral Healthcare, complying with Regulations of the State Board of Pharmacy, Commonwealth of Virginia.
3. Provide pharmacy services from 8:30 a.m. to 4:30 p.m. Monday through Friday, except on holidays recognized by the Commonwealth of Virginia.
4. Provide professional supervision by the RCAHD pharmacy director of the Blue Ridge Behavioral Healthcare pharmacist hired in accordance with this agreement.
5. Provide pharmacy patient care management, including monitoring of all medications provided for possible contra-indications and adverse drug reactions to clients of BRBH.
6. Provide courier service to Blue Ridge Behavioral Healthcare, The Burrell Center, 611 McDowell Avenue, Roanoke, VA 224016 for injectible medications or any other medications housed at The Burrell Center.

7. Provide patient medication education to BRBH consumers and provide medication information handouts for medications dispensed.
8. Provide consultation and support to BRBH physicians and nursing staff in discussions and decision-making concerning medications.
9. Inspect, on a monthly basis, medication storage and administration areas at the following BRBH locations: The Burrell Center, the Shenandoah Recovery Center and Hegira House. Written reports with recommendations to be submitted to the Program Directors with copies to the BRBH Director of Quality Management.
10. Bill all appropriate third party payers for services, revenues received are to be posted to the Blue Ridge Behavioral Healthcare account and are to be used to offset the amount of BRBH reimbursement .to RCAHD acquisition cost of medications.
11. Provide all overhead requirements (space, QS1 computer system, computers, telephones, etc.) necessary to fulfill the above requirements.
12. Sign a Business Associate Agreement that complies with HIPPA requirements.
13. Review this Agreement on a quarterly basis for the first year and semi-annually thereafter for process review and quality assurance purposes.

B. Blue Ridge Behavioral Healthcare will:

1. Hire one (1) full time pharmacist to be stationed at the Health Districts Pharmacy located at 515 Eighth Street SW, Roanoke, VA 24016 and supervised by the Roanoke City and Alleghany Health District pharmacy director.
2. Reimburse the Health Districts for 50% of a current Roanoke City and Alleghany Health District Certified Pharmacy Technician. Currently estimated at $14,500 per year.
3. Reimburse the Health District for the acquisition cost, less any third party payer reimbursements, of all medications dispensed to clients of Blue Ridge Behavioral Healthcare.
4. Participate with RCAHD in the reviews for process and quality assurance purposes of this agreement on a quarterly basis and semi-annually thereafter.

III. Personnel

A. All employees assigned under this agreement must comply with the human resource policies and procedures of their respective agencies.

B. Employees are expected to attend staff meetings and appropriate training sessions and in-service programs.

IV. Terms and Termination:

A. This agreement shall become effective on **XXXXX, 2004** and will continue until **XXXXX** and shall be reviewed and renewed annually thereafter unless modified or terminated as hereinafter provided.

B. This agreement may be modified by written agreement of both parties. Thirty (30) days written notification of the proposed modification is required.

C. Any party to this agreement may terminate the agreement by providing written notice to the other party ninety (90) days prior to the proposed termination.

Signed _____

S. James Sikkema, LCSW
Executive Director, Blue Ridge Behavioral Healthcare

Signed _____

Molly O'Dell, MD
Director, Roanoke City and Alleghany Health Districts

REGION VII
CATAWBA REGIONAL PARTNERSHIP
RESTRUCTURING PROJECT

PROJECT MANAGER POSITION DESCRIPTION

This position provides project management and coordination services for the development, implementation and maintenance of the Catawba Regional Partnership Restructuring Project. This is a temporary, full-time position with continuation dependent upon future funding availability.

The Catawba Leadership Team (CLT) or its designees recruits and selects the Project Manager. BRBH provides direct day-to-day supervision of this position. This position functions are consistent with a BRBH approved position description, work plans and assignments. The Project Manager is evaluated by the CLT or its designees.

Responsibilities:

1. Attends CLT meetings to report and receive direction on project development and implementation issues and to participate in problem solving discussions.
2. Develops, implements and maintains a regional monitoring and tracking system that reports:
    a. levels of services delivered
    b. consumer outcomes
    c. pharmacy utilization
    d. clients served, ALOS in services, etc.
    e. financial information (reimbursement, costs, etc.)
3. Prepares and submits reports to CLT and DMHMRSAS as required.
4. Provide leadership to project staff supervisors to determine and insure compliance with design.
5. Identify problems and concerns along with solutions as project is implemented and is maintained.
6. Performs other related activities as defined by CLT. Additional responsibilities will be developed that will result in changes in this position description when full implementation occurs.

Knowledge, Skills and Abilities:

1. Thorough knowledge of the services, programs, service providers and populations to be served by the CLT.
2. Thorough knowledge of management principles and practices applicable to behavioral health programs.
3. Excellent knowledge, skills and abilities in Microsoft Office and Report Writing programs.

4. Excellent skills in oral and written communication and generation of program reports, utilization reports, quality improvement reports and project updates.
5. Knowledge of health management information systems (Anasazi) including clinical record management and reimbursement billing functions.
6. Ability to creatively develop solutions and strategies to resolve healthcare system issues and barriers for consumers.
7. Ability to work independently yet function effectively as a team member with multiple levels of supervision and guidance.
8. Ability to set priorities and effectively manage time and projects.
9. Excellent ability to communicate effectively with a wide variety of individuals including consumers, families, advocates, staff, and the general public.

CATAWBA REGIONAL PARTNERSHIP
DISCHARGE ASSISTANCE PROJECT FUNDS
FY-05

The allocation from DMHMRSAS for Regional Discharge Assistance Project (RDAP) funds is: $250,000 for FY-05 and $375,000 for FY-06.

- The funds in the first year will be used to secure placements at Learning Services, Inc. residential programs for two Roanoke Valley people with acquired brain disorders. Both are currently on the extraordinary barriers list at Catawba Hospital
- Two individuals from Alleghany Highlands are targeted for RDAP funds for special needs pending discharge, including surgery.

As the Fiscal Agent, BRBH will pay all bills submitted and approved by AHCSB management for reimbursement through its Financial Services Dept. Reimbursement documentation will be submitted to BRBH Financial by BRBH staff overseeing the consumers receiving RDAP funds.

Catawba Region Regional Partnership Project
Treatment Process Workgroup

Proposal of Strategies and Recommendations for Integrated Service Delivery

MISSION: To improve, enhance, and promote a seamless treatment process to support recovery of persons with severe mental illness

RAPID RESPONSE TEAM

1. Provide 1 FTE Case Manager, and the capacity for on-call rapid case management response (using the model for "on call" capacity of BRBH staff currently utilized by Crisis Services) during weekends and holidays.

2. Goals:
   - to reduce length of stay in private hospitals for clients hospitalized with short-term needs;
   - to avoid, where possible, transfer of clients from private hospitals to Catawba, by facilitating prompt access to BRBH/AHCSB and other community services that will support client stabilization;
   - to avoid hospitalization, where feasible, of patients who are evaluated as being able to stabilize with immediate access to community supports.
   - to manage diversions to such an extent that Catawba Hospital will be able to serve patients needing admission from the AHCSB.

3. Rapid Responders would serve the following functions in order to achieve these goals:
   - In consultation with other BRBH/AHCSB Crisis Services staff, identify those clients admitted each day to a private psychiatric hospital who can be recommended for a rapid discharge rather than transfer to Catawba, as well as those clients who can be diverted from psychiatric hospitalization through the provision of immediate services – negotiated from the ER - that will facilitate stabilization, and proceed to identify and locate the resources that can facilitate such discharge or diverted admission. Examples:
     - New (or closed) clients: Immediate opening to BRBH/AHCSB services, either through BRBH/AHCSB assessment providers, through the Rapid Responder doing the intake/assessment, or through SRC admission for BRBH consumers; immediate establishment of appointment time with other BRBH/AHCSB providers; treatment team participation with other providers to ensure rapid onset of appropriate services. Maintain an active role in providing initial interventions until other supports are identified.

- Open clients: Immediate arrangements negotiated with all providers re: rapid provision of services from the home CSB that will support stabilization (psychiatric, case management, MH supports, SRC for BRBH consumers, emergency housing – preferably in the consumer's home catchment area).
- Negotiation with hospital for 5 days of medication, and CSB psychiatric services appointment within 5 days;
- Negotiation with any service provider that can facilitate stabilization.

4. When there are no patients in private hospitals whose discharge could be facilitated by this case manager, the case manager would support discharge planning efforts for short-term patients at Catawba Hospital.

BUDGET:

$59,000	All personnel costs for 1 FTE Case Manager
11,000	On call staff for weekends and holidays
5,000	Medications
25,000	Emergency housing

ESTIMATED CONSUMERS IMPACTED:

154 hospital bed days saved would be comparable to reimbursing private hospitals @ $650 per day.

455 emergency housing bed days could be provided @ $55/day. All consumers would not need the emergency housing option.

While it is difficult to project the volume of consumers who could be discharged rapidly from a private hospital, it is likely that the number of bed days saved would be considerably higher than 154. Additionally, considerable staff time would be saved that is currently spent in protracted discussions about transferring patients to Catawba, and the volume of Catawba transfers would be reduced.